People with Complex Needs

Alberta
GOVERNMENT OF ALBERTA

Acknowledgements

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For more information or to order copies of this booklet, please contact:

Community Partnerships Unit
#900 – 10055 – 106 Street
Edmonton, Alberta T5J 1G3
Fax: (780) 427-9145

Please feel free to copy and distribute this booklet.

This booklet is consistent with the Youth in Transition Protocol, which can also be obtained at the above address.

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Introduction

Introduction

This manual will help human service providers integrate their activities and better serve clients with complex or multiple needs. Integrated Supports and Service Planning for People with Complex Needs helps the person with a disability, their informal support network, agencies and communities work together to improve the planning, delivery and evaluation of supports and services.

The process of working together to integrate supports and services can be complex and challenging. This manual is designed to help human service providers by providing practical guidelines, tools and strategies to guide the planning process.

Objectives

The objectives of this manual are to:

- outline the goals and principles of an integrated approach to planning for people with complex needs;
- describe a process for getting formal and informal supports and services working together in an integrated manner;
- identify attitudes, knowledge and skills required to effectively integrate supports and services;
- give human service providers an opportunity to examine creative ways to integrate supports and services;
- identify roles and responsibilities of key formal and informal support people;
- identify decision-makers; and
- establish a process to deal with issues as they arise in the process.

Definitions

Definitions

This process has been called Integrated Supports and Services Planning for People with Complex Needs, although Integrated Case Management is often the term used to describe planning processes for *clients*. Many people with disabilities object to these terms, indicating they are neither *cases* nor do they need *managing*. To be sensitive to people's reaction to being *clients*, they are referred to as people or individuals rather than clients. Terms are defined below:

Caregivers: Includes human service providers, family and natural support networks.

Collaboration: The most sophisticated level of interagency relationships. It is an intensive and jointly planned effort by organizations to address mutual concerns and arrive at a mutually desired outcome. A relationship among two or more agencies exists in which the parties share common goals, mutual commitments, resources, decision making and evaluation responsibilities.

Cooperation: A process of working together to achieve goals and mutual benefits. Members of the team interact to provide information, support and/or referrals.

Coordination: A process of enabling independent organizations, staff and informal supports to work together. It involves establishing a common understanding of the services and supports provided by each participant and by determining each participant's accountability and responsibility. Unnecessary duplication is identified and eliminated, allowing resources to be shifted and reallocated to fill voids and gaps in the supports and service system.

Community: A group of people bound together through mutual interests and sense of shared destiny based on ethnic, racial, culture or geographical boundaries (such as neighbourhood, town, city or region) or non-geographical boundaries (such as an interest group dispersed across the province, workplace, business organization, professional association or ethnic/cultural group).

Human Services: Services to help individuals meet their physical, psychological, and/or social needs. These include health, education and training, social, justice, housing, recreational and cultural services.

Human Service Providers: Includes people (independent or associated with agencies) who are paid to provide services to individuals. This may also include volunteers who are affiliated with a formal agency or program.

Individual with complex needs: (individual, person) An individual with complex physical, psychological, mental, social and/or spiritual needs and who receives services from more than one human service agency.

Integration: A process that ensures consistency of principles, goals, objectives, strategies and actions among supports and services and looks holistically at needs of individuals and how to meet those needs.

Integrated Supports and Services Planning (Service Plan, Care Plan): A series of goals, interventions and responsibilities providing a cohesive and integrated approach to address the identified strengths and needs of an individual with complex needs.

Integrated Supports and Services Planning for People with Complex Needs: Since Integrated Supports and Services Planning implies a team approach to planning, a designated planner is required to ensure the coordination of activities. These activities include assessing, planning, coordinating, implementing, monitoring and evaluating.

Natural Support Network: Includes family, friends and/or volunteers who naturally and actively provide support to individuals and families.

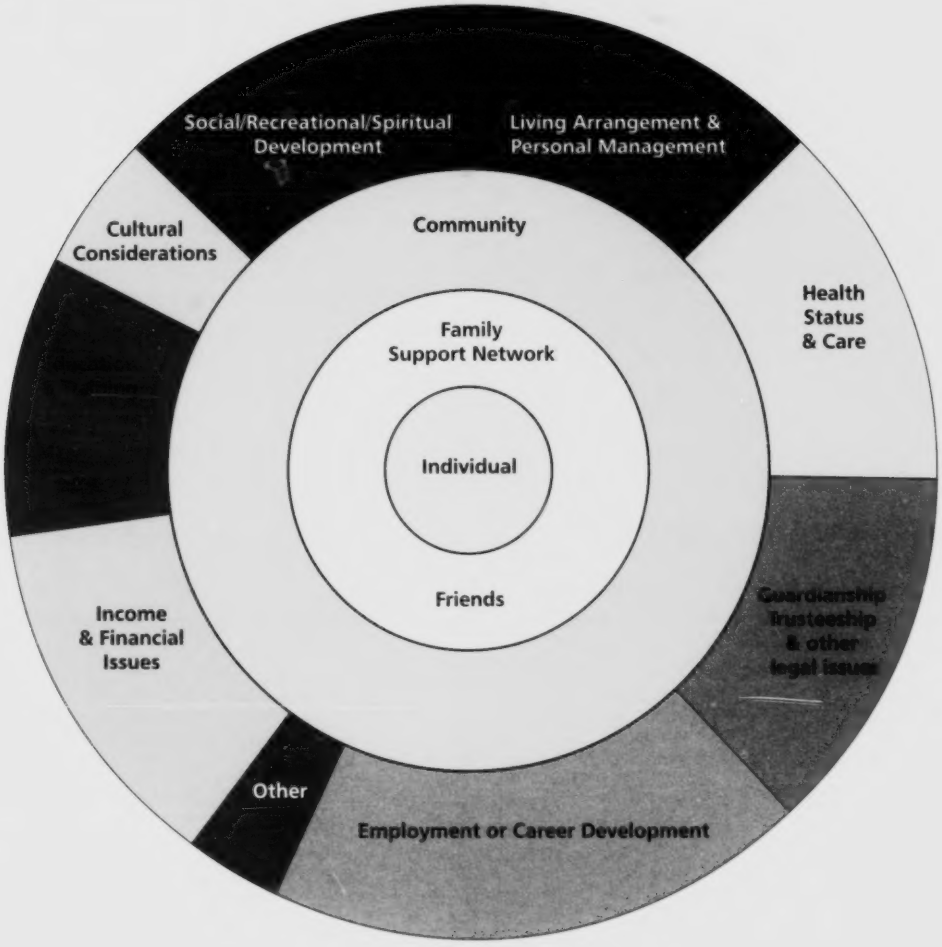
Team Lead/Facilitator: The person who oversees the Integrated Supports and Services Planning process on behalf of an individual with complex needs.

Integrated Supports and Services Planning

Integrated Supports and Services Planning involves a Circle of Support, which addresses the basic areas of life and the formal and informal supports that address these essential elements. Since human needs are so interrelated and connected, meeting the diverse needs of a person is best met through a holistic and integrated approach to planning.

An individual's Circle of Support includes family, friends and formal support services working together with the individual.

Circle of Support



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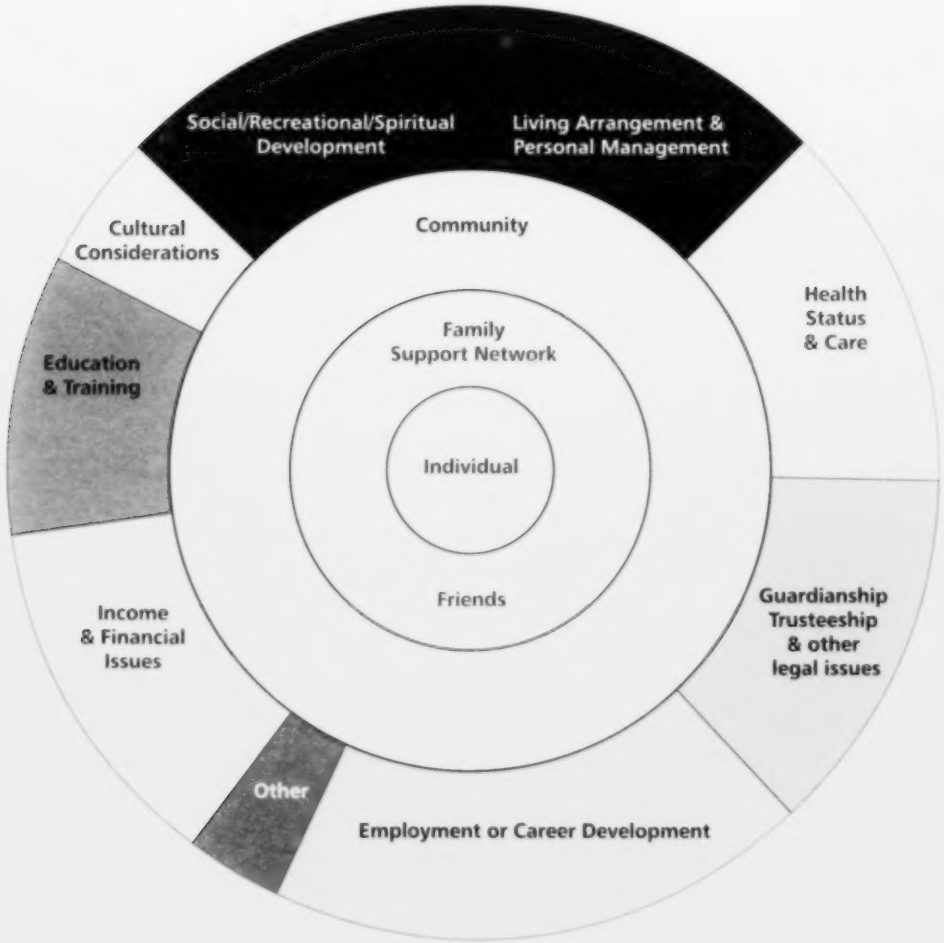

Goal

The goal of integrated planning is to be proactive and provide responsive, holistic and effective supports and services that contribute to the well-being of people with complex needs.

Principles

Person-Centred Approaches:

- recognize and build on strengths, interests and successes;
- respond to individual needs and expectations;
- respect individual dignity, responsibility and self-determination;
- recognize that individuals exist within the context of a community;
- ensure individuals are informed, provided with options and encouraged to participate in making decisions; and
- respect the importance of confidentiality but share information on a need-to-know basis when directed by the individual.

Holistic Approaches:

- emphasize the complete and interrelated nature of individuals', families' and communities' needs and strengths; and
- acknowledge that no single group can address all the needs of an individual or family; and recognize the interdependent nature of supports and services.

Integrated Approaches:

- promote the coordination of planning, decision making and resources through a multi-sector and multi-disciplinary team approach;
- foster good communication, cooperation and collaboration amongst service providers, individuals and networks of support; and
- reduce service fragmentation to improve effectiveness and continuity; and meet individual needs in a comprehensive, coordinated and integrated manner.

Accessibility and Equity:

- ensure access to timely and appropriate services; and
- foster a respectful, barrier-free environment, where individuals have opportunities for equal access and equal benefit.

Preventive Approaches:

- promote early intervention aimed at preventing crises; and create opportunities to educate individuals, communities and service providers.

Shared Responsibility and Mutual Respect:

- enable individuals, communities and human service providers to work together to identify needs, effective solutions and responses;
- promote shared leadership, planning, decision making, resources and evaluation;
- acknowledge mutual respect for the expertise and contribution of each participant;
- recognize the role of the family, other caregivers and community resources in planning and caring for individuals; and
- ensure that the rights of individuals and others are protected.

Accountability and Affordability:

- promote efficient, effective and equitable use of resources to achieve positive outcomes;
- provide opportunity and information for human service providers to plan collectively for individuals; and
- provide a framework for accountability to the people and communities being served.

Documenting the Process:

Documentation of the process is critical to the planning and monitoring of supports and services. Getting used to new forms takes additional effort and commitment. With time, the forms become easier to use, and it is easier to see the benefits of documenting the process. A well documented process saves time and allows those involved to:

- √ identify what is being done and by whom;
- √ record supports, services and outcomes;
- √ demonstrate good practices; and
- √ submit reports as required and report to legally responsible parties.

The responsibility for record keeping lies with the Team Lead/Facilitator, who may chose to delegate this task. The person responsible for keeping records maintains the master file and ensures that the forms are complete, accurate and up-to-date. In addition, members of the team may chose to keep a full copy of the forms.

NOTE: Each record needs to be dated and include the full name of the person responsible for the entry.

Suggested forms for recording Integrated Supports and Services Planning activities have been included in Appendix A. Each form is numbered in the top left hand corner. Filling out forms accurately is essential to good practice and to evaluation of the process.

Process and Components

The planning process involves a number of activities, typically in the following sequence:

1. Initiating the planning process and inviting participation
2. Identifying a Team Lead/Facilitator
3. Identifying strengths, circle of support and assessing needs
4. Planning and implementing supports and services
5. Monitoring and evaluating
6. Transferring and closure

1. Initiating the Process

Which individuals or what needs are best suited to the Integrated Supports and Services Planning Process for People with Complex Needs?

There are no recipes for identifying the individuals best suited to the Integrated Supports and Services Planning process. As any experienced worker will say, it is often more art than science. However, there are individuals who are more likely to need and to benefit from Integrated Supports and Services Planning. People with complex and/or multiple needs; families with more than one member who has human service needs and those who require supports and services from more than one agency, sector or worker are most likely to benefit. The more workers, agencies and/or sectors involved, the more likely this integrated process will be needed.

When should the Integrated Supports and Services Planning Process begin?

In an ideal situation, supports and services are in place at a time of transition or before an inevitable crisis. Integrated Supports and Services Planning provides an opportunity for early intervention. An early and well-planned response avoids gaps, duplication and confusion, and contributes to a plan that addresses the multiple needs of an individual.

Experience improves the ability to anticipate which individuals will benefit most from this process. Sometimes, there are people whose needs come to the attention of a human service worker or agency when the individual has already reached a crisis or for whom a single agency approach has not been successful. At other times, it is only when other approaches have not worked that the need for the Integrated Supports and Services Planning approach is identified.

> Form 1 in Appendix A may be used to help make the decision when and whether a particular individual needs an Integrated Supports and Services Planning process. Once this decision is made, the Team Lead/Facilitator initiates the meeting with the individual, his/her family and all critical people involved in planning for the individual's needs.

Who begins the process and how?

In many situations, the complex and multiple needs of an individual and family will mean that they need service providers to take the initiative and become their advocates and supporters. A service provider, along with the individual and family, may decide that the needs of the individual are best served through an integrated approach to supports and services. Once this decision is made, the service provider initiates a meeting with all critical people involved in planning to meet the individual's needs.

The initial meeting may occur in a joint meeting or by telephone when time or distance present significant barriers. The initiating service provider needs to assess the individual's situation and any risk factors in the individual's environment before deciding how the process will occur. The more difficult and complex the circumstances, the more important it is that the initial interventions be planned and integrated in a face-to-face process.

The person with complex needs should be prepared for the process and dynamics of an Integrated Supports and Services Planning approach. It is a good idea to talk with the individual about:

- √ reasons for the meeting;
- √ steps in the process;
- √ who should attend meetings;
- √ nature of the discussions;
- √ their role and the role of human service providers'; and
- √ their agreement with this approach

Note that no one particular service provider or department is charged with the responsibility for initiating a joint planning process. Any human service provider could be responsible for identifying when an integrated approach is required. All human service providers could initiate an Integrated Supports and Services Planning process when needed.

Form 2 in Appendix A may be completed by the person initiating the process to provide to invitees to the initial meeting.

Who are the Team Members?

Depending on the needs of the person with complex needs, human service providers and other individuals form a team to work together. People receive support and services from many different service providers and agencies. In most cases, at least two agencies will be involved in the planning process. The combinations of disciplines, expertise and agencies to consider are based on the needs of the person and the services they currently receive. The experts to consider could include:

- Advocates
- Alcohol and Drug Counsellors
- Child and Youth Care Workers
- Community Agencies/Human Service Providers
- Elders
- Employers
- Health Professionals
    - occupational therapists
    - physical therapists
    - registered psychiatric nurses
    - registered nurses
    - speech-language pathologists
    - physicians
- Lawyers and Judges
- Police Officers
- Private Practitioners
- Probation Officers
- Public Trustee Officers
- Public Guardian Representatives
- Psychiatrists
- Psychologists
- Post Secondary Special Needs Counsellors
- Resource or Learning Assistance Teachers
- Social Workers
- Spiritual Leaders
- Supportive Housing Providers
- Teachers
- Victim Services

Individual, Family, Informal Caregivers and Friends

While professional and agency representatives may have expertise about services and programs, the individual, family and informal caregivers are the experts about themselves and are central to the planning process.

Extended family members may have an inherent understanding of family dynamics, strengths and current support systems. They are the people who share the day-to-day experience with the individual and who can report to the rest of the team about how the plan is working. They are also the people who will know whether the process is effective or not. Their feedback and suggestions are essential to the successful functioning of Integrated Supports and Services.

2. Identifying a Team Lead/Facilitator

It is important to determine who the Team Lead/Facilitator will be, and it may not be the person who initiated the process. This identification is essential to the success of the planning process. The responsibilities of the Team Lead/Facilitator will often be in addition to his/her direct service responsibilities.

Selection should be based on the Team Lead/Facilitator's ability to:
- √ support the involvement and decisions of the individual and family;
- √ facilitate a collaborative approach and understand the role;
- √ maintain contact with those involved in the case; and
- √ commit to the Integrated Supports and Services Planning process.

The Team Lead/Facilitator may be a caregiver, an advocate or one of the service providers involved with the individual. The selection process could be done by nomination or appointment, vote or on a volunteer basis. The person who is identified as the Team Lead/Facilitator commits to ensuring that the Integrated Supports and Services Planning process is followed and the individual is encouraged and supported to participate as a partner.

What Does a Team Lead/Facilitator Do?

The Team Lead/Facilitator ensures that the best interests and well-being of the individual and family are foremost. The specific duties include:
- √ organizing and chairing meetings;
- √ encouraging individual involvement;
- √ ensuring a plan is developed and the roles of team members identified;
- √ ensuring the establishment and follow through on monitoring progress;
- √ ensuring contact is maintained between the team and external referrals;
- √ determining a process for conflict resolution or mediation when necessary;
- √ ensuring all paperwork and files are accurate and up-to-date; and
- √ ensuring that meeting records are compiled, maintained and distributed.

Form 3 - Integrated Supports and Services Planning Team. Can be completed once the Team Lead/Facilitator and team members are identified. In recognition of the commitment and added responsibility of leadership, the form can be given to the Team Lead/Facilitator's supervisor as the work load of the Team Lead/Facilitator may need to be adjusted to accommodate for the increased responsibilities.

3. Identifying Strengths, Circle of Support and Assessing Needs

Once the team members and team leader are chosen, the team will gather and pool information for the purpose of describing the circumstances of the individual at the beginning of the process. Identifying strengths as well as problems is important, since working with strengths can be more effective than only working with weak or problem areas.

Form 4 - Assessment Summary Form – Use this form to record the individual's strengths and needs. The basic elements of life are identified to help the team develop a complete picture of the person. Even where there are no concerns in an area, identify strengths that may be used to offset areas of weakness. Identify the person who completes each area of the assessment so a contact is available for additional information or clarification.

What are the areas of assessment that need to be considered'?

Areas of assessment:

√ Individual's dreams, goals and ambitions
√ Support network and connections
√ Guardianship, trusteeship and other legal issues
√ Cultural considerations
√ Health status and care
√ Living arrangements and personal management
√ Income and financial issues
√ Education and training
√ Employment or career development
√ Social, recreational and spiritual development
√ Other

Individual's dreams, goals and ambitions

√ What are the individual's strengths, abilities and interests
√ What are the individual's short and long term goals?
√ What are their preferences and opportunities?
√ What obstacles and barriers exist and are there possible solutions?

Support network and connections

√ Who are the person's significant friends and acquaintances?
√ Is family involved, and what is the nature of the relationships?
√ What is the legal relation between the person and family members – does the person need an advocate?
√ What needs related to family and informal networks have been identified?

Guardianship, trusteeship & other legal issues
Consider the individual's ability to make his/her own decisions. Include legal decisions, probation, other court orders and possible legal action on behalf of the individual if an injury or crime has occurred.
√ Should full or partial guardianship be considered?
√ Could the person benefit from either a formal or informal trustee?
√ Is the person involved with the criminal justice system?
√ Would a Personal Directive provide further protections?

Cultural considerations –The individual's specific cultural needs and desires.

Health status and care - The individual's life-style, nutrition, sexual health, emotional, psychological, physical, developmental, behavioural and mental functioning.
√ What is the person's perception of his/her well-being?
√ What problems or difficulties does the person identify needing help with?
√ What does the person think would help address his/her need(s)?
√ Do addiction and/or birth control issues need to be addressed?
√ What health needs have been identified?

Living arrangements and personal management - The safety, stability and suitability of the place where the individual lives and their skills to manage in this environment.
√ What is the person's perception of his/her residence?
√ What problem does he/she perceive, if any?
√ What changes are needed short term and long term?
√ What needs related to housing have been identified?
√ Does the person require assistance with activities of daily living?
√ What skills do they have in household management?
√ What support do they need for personal care and hygiene?

Income and finances - The individual's financial well-being and ability to manage.
√ Does the person perceive needs/problems related to finances?
√ What does the person think would help address his/her need(s)?
√ What needs or issues related to finances have been identified?
√ Would financial management supports, like the AISH Benefits Administration Program, help with money management?

Education, training - An individual's past and/or current education experiences, as well as information regarding specific strengths and/or special needs.
√ Does the person have an interest in education/training?
√ Are there needs for financial supports for education/training?
√ What are the needs or issues related to education/training (equipment/environmental accommodation, note taker)?

Employment or career development - Employment and career potential, suitability and status.
√ Does the person perceive needs or problems related to finding meaningful work and what does he/she think would help address his/her need(s)?
√ Have the options of work experience, employability skills and interests, supportive employment and volunteer experiences, opportunities and interests been explored?
√ What needs or issues related to vocation have been identified?

Social, recreational and spiritual development – The individual's social and recreational interests and abilities as well as peer influences.

√ To what extent is the person able to participate in activities he/she wishes to? Are there barriers to participation?
√ What does the person think would help address his/her need(s)?
√ What are the person's ethnic/spiritual/linguistic strengths? Needs?
√ What activities and groups are/have been significant to the individual?
√ Does the person have hobbies and interests?
√ Does the person engage in sports or fitness activities, religious/ spiritual groups, volunteer activities?

Other - There may be areas that require attention but do not readily fit in any of the categories listed. For example, transportation needs may be an issue for consideration in the planning.

4. Planning and Implementing Supports and Services

Integrated Supports and Service Planning is based on the information contained in the **Form 4 – Assessment Summary**. The team, including the person with complex needs, develops goals and strategies in each focus area and identifies responsibility for specific activities. This ensures that each member of the team is aware of the other's involvement and contribution. Some areas may not have been addressed, and joint planning needs to occur to avoid fragmentation and duplication. Chances for success increase when Integrated Supports and Services Planning goals are concrete and focused on the best interests of the individual.

Form 5 – Integrated Supports and Services Plan. Goals, actions, and responsibilities are identified in each of the focus areas.

5. Monitoring and Evaluation

Monitoring is absolutely essential to successful Integrated Supports and Services Planning and unfortunately, is the easiest to let slip. Regular meetings of the team keep all members informed, measure progress and allow for plan modification to respond to new circumstances or an ineffective plan. This process is time-consuming, but it is an effective way to build in preventive approaches.

When the integrated supports and service plan is developed, a date is set for the follow up meeting, and the team agrees on how often meetings are needed.

Frequency of the meetings is determined by the following factors:

- Individual and family wishes – the individual and family often have the best sense of how things are going.
- Planning stage – frequent meetings in early phases ensures that the plan is working.
- Life circumstances – stressful circumstances in the life of the individual or family make them more vulnerable, and they may require more support.
- Milestones – holidays, anniversaries (of happy and sad occasions), beginning of school, employment, court appearances and other milestones can be vulnerable times and need to be considered.
- Significant changes in the team composition – new members of the team may need more frequent meetings to become familiar with the planning process. (Note: individual new members should be brought up to date by the Team Lead/Facilitator prior to the meeting.)

Form 6 – Monitoring. Each area in the plan is monitored and modified as needed. A form needs to be filled out for each meeting and kept in the Integrated Supports and Services Planning file.

Evaluation needs to be a part of the Integrated Supports and Services Planning process. It may take place while the plan is being implemented, when a decision is being made and once a file has been transferred or closed.

Form 7 – Evaluation. Completing this form provides an opportunity to assess how the team implemented or is implementing the integrated supports and service plan.

6. Transferring or Closure

The transfer or closures of files are purposeful events that need to be documented. If an individual moves to a new location, the Team Lead/Facilitator needs to identify a contact in the new community and send a complete copy of the Integrated Supports and Services Planning file. This requires the informed consent of the individual. When an individual or family member is the Team Lead/Facilitator, the file can travel with that person. Team members should help the individual or family member make appropriate contacts in the new community. If the file is to be closed, it needs to be done by consensus.

Form 8 – File Transfer or Closure. The date of transfer or closure and reasons are identified (e.g. moving, goal attainment).

Positive Practice Strategies

Positive Practices

There are challenges when trying to integrate the principles, roles and processes of Integrated Supports and Services Planning into day-to-day practice. Experienced professionals use a combination of practices to solve problems effectively.

Focus on Needs not Services – Discussion sometimes focuses on what services the individual and/or family are eligible for and what services the agency offers, rather than focusing on individual needs. This may result in a service provider-oriented discussion instead of one that focuses on the individual. Start with the question What are the individual's needs? Avoid questions that emphasize how a person can be accommodated within current mandates or availability of services. Those kinds of questions are not likely to lead to a person-centred plan.

Use a Holistic Approach – Most of us are trained to become specialists in our field; however, one specialist cannot meet multiple and complex needs. The baggage of turf protection is weighty and can prevent us from working collaboratively and meeting individual needs. Integrated Supports and Services Planning calls for a coordinated and multi-disciplinary approach. It encourages cross-discipline learning and sharing of information and fosters a multi-disciplinary approach to meet the needs of people. Working in this way requires mutual respect, vigilance, flexibility and openness.

Use Clear Language – When individuals, families and human service providers from various disciplines make up a team, it is important to speak in a language that is clear to everyone. This is challenging because each discipline has its own jargon. The importance of clear communication for everyone on the team must be kept in mind.

Establish a successful planning environment using the following practices:

- Eliminate acronyms and explain complicated terms to create common understanding.
- Include the person and their family in discussions.
- Adopt a holistic perspective when addressing needs, linking planning to strengths.
- Learn about other disciplines and resources. Try to understand all perspectives.
- Be creative when planning and look beyond existing service mandates and eligibility.

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- Be creative when planning and look beyond existing service mandates and eligibility.

Belief System and Values -

A belief system provides us with our interpretation of the world, influences our behaviours and forms our convictions. Our choices, decisions and actions are influenced by our belief system. Every day, we are faced with situations that require us to make choices and decisions and carry out actions. Some are quite casual and familiar, others require deliberation and have significant consequences in our lives. Our belief system also influences our professional practice.

Tool 1 – Check Your Belief System provides a way to examine our beliefs and ways of working with individuals and families. Exploring our belief system may raise an awareness of our own biases and values and help us to practice Integrated Supports and Services Planning according to the principles.

Biases – One example of a frequently occurring bias is classism. Many people with complex needs are poorer and less educated than their human service providers. This can cause misunderstandings and stereotypical assumptions on all sides. Individuals may be seen as less competent, intelligent and responsible than they are. Professionals may be seen as more arrogant, distant and uncomprehending than is the case. Clearly, however, the inherent power imbalance in favour of human service providers makes the issue more serious when professionals do not recognize their biases. In our society, there is no guarantee that various systemic biases will not be represented around the table – racism, sexism, or discrimination against old and young persons may well be present. Professionals are not immune from other prejudices, such as those having to do with sexual orientation, obesity or visible handicaps.

Blaming the Victim – A planning conference is the time for everyone to model the principles of Integrated Supports and Services Planning such as shared responsibility and mutual respect. It is not useful to blame the individual or confront their denial.

Address challenges related to your belief system as follows:

- Recognize your own biases and explore how they influence your behaviour.
- Learn to recognize the biases of others and consider how they influence their behaviour.
- Understand and respect cultural, class, physical and other differences among people.
- Exercise sensitivity in terms of how issues are described and talked about.

Skills -

Skills that enhance professional, individual and family partnerships are crucial in delivering Integrated Supports and Services. Appendix B contains tools that provide an opportunity to rate some person-centred and team work intervention practises as follows:

Tool 1 – Check your belief system
Tool 2 – Cultural competencies
Tool 3 – Listening
Tool 4 – Information sharing
Tool 5 – Team meeting practice
Tool 6 – Group problem-solving

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Tool 1 – Check Your Belief System provides a way to examine our beliefs and ways of working with individuals and families. Exploring our belief system may raise an awareness of our own biases and values and help us to practice Integrated Supports and Services Planning according to the principles.

Biases – One example of a frequently occurring bias is classism. Many people with complex needs are poorer and less educated than their human service providers. This can cause misunderstandings and stereotypical assumptions on all sides. Individuals may be seen as less competent, intelligent and responsible than they are. Professionals may be seen as more arrogant, distant and uncomprehending than is the case. Clearly, however, the inherent power imbalance in favour of human service providers makes the issue more serious when professionals do not recognize their biases. In our society, there is no guarantee that various systemic biases will not be represented around the table – racism, sexism, or discrimination against old and young persons may well be present. Professionals are not immune from other prejudices, such as those having to do with sexual orientation, obesity or visible handicaps.

Blaming the Victim – A planning conference is the time for everyone to model the principles of Integrated Supports and Services Planning such as shared responsibility and mutual respect. It is not useful to blame the individual or confront their denial.

Address challenges related to your belief system as follows:

- Recognize your own biases and explore how they influence your behaviour.
- Learn to recognize the biases of others and consider how they influence their behaviour.
- Understand and respect cultural, class, physical and other differences among people.
- Exercise sensitivity in terms of how issues are described and talked about.

Skills -

Skills that enhance professional, individual and family partnerships are crucial in delivering Integrated Supports and Services. Appendix B contains tools that provide an opportunity to rate some person-centred and team work intervention practises as follows:

Tool 1 – Check your belief system
Tool 2 – Cultural competencies
Tool 3 – Listening
Tool 4 – Information sharing
Tool 5 – Team meeting practice
Tool 6 – Group problem-solving

Systemic Barriers

Some barriers to integration may relate to some traditional practices, beliefs and values. Other barriers, which at first glance may appear insurmountable, may be related to the way that organizations implement legislation, policies, procedures and financial decisions. Overcoming these systemic barriers is a shared responsibility and human service providers may play a role.

Confidentiality/Sharing Information -
There may be confusion and frustration among human service providers related to issues of confidentiality and information sharing. Understandably, people become frustrated when information is not shared, regardless of the reasons given. Cooperative and collaborative efforts are undermined, and service continuity for individuals is impeded when team members misinterpret or use rules of confidentiality to prevent information sharing.

Duplication and Overlap -
The Integrated Supports and Services Planning approach helps prevent situations where human service providers are working in isolation to meet the same needs of an individual. It is important that team members work together to avoid duplication of effort, time and resources.

Service Mandates -
Sometimes service mandates and the way they are interpreted can hinder the Integrated Supports and Services Planning process and interfere with problem-solving. There are times when it is appropriate and necessary to be flexible, expand and go beyond service mandates.

Human Resources and Workload -
Collaboration and meeting times need to be built into the work plans and day-to-day work lives of front-line workers. Sometimes, collaboration is considered an add-on duty and not given priority when human service providers' time is stretched to the limit.

Funding Issues -
Funding is often an issue that needs to be addressed. Sometimes there are funding barriers because there is a lack of knowledge of how to access funds, or agencies, systems and organizations are inflexible in allocating funds. Other times, there may be inadequate funding, or a lack of collaboration amongst agencies in sharing and pooling resources to meet individual needs and achieve collective goals.

Accountability -
Accountability needs to be built into the Integrated Supports and Services Planning process. Team decisions and actions need to be supported by managers and organizations, while at the same time, key members need to be assigned responsibility for action and follow-up. Ultimately, accountability must be defined and acknowledged on a person-by-person basis. Without this step, services may not be implemented as planned and the plan may be ineffective.

Change -
Change is difficult for most people. Resistance to change may be a significant challenge to adopting an integrated approach to planning supports and services. Difficulty dealing with

change can impede effective integration of human services. Positive change is a part of the integration process, which includes:

- innovative alternative delivery systems (e.g. community-based rather than institutionally-based services);
- emphasis on preventive care;
- advances in technology that change the way services are provided; and demands for cultural awareness.

Climate, Time and Distance Factors -

In the North and in rural areas, climate, time and distance are often obstacles to collaboration. At times, it is difficult for human service providers to attend meetings, to collaborate with other agencies and to be involved in Integrated Supports and Services Planning. Time and distance are major barriers because so much time is spent travelling rather than working in meaningful ways with individuals and/or other human services providers.

Approaches to Address Barriers -

Integrated Supports and Services Planning team members, including individuals and their families, will often develop the most creative and effective solutions to challenges. While it is important to note the distinction between person specific and larger systemic barriers, approaches to address them may be similar. There are a number of strategies that teams and organizations can use to support the integration of human services. Some examples are:

Impact Statement

Whenever a decision is made by human service providers, managers, government and agency leaders, the following question needs to be asked:
How will this affect the integration of supports and services?
If everyone involved keeps in mind the implications of small and large decisions, barriers to Integrated Supports and Services Planning may be broken down and overcome.

Group Problem-Solving

The team's success depends on its ability to use a creative and supportive problem-solving approach to deal with barriers related to Integrated Supports and Services. Problem-solving as a group, sometimes making compromises, and at other times making tough decisions, is essential to the process. Therefore, the involvement of all partners in overcoming barriers must be emphasized. One group problem-solving approach is included in Appendix B.

Funding

Develop procedures for allowing funds to be used in ways that encourage cooperation amongst agencies (e.g. pooling funding, when funding is in one pool, agencies need to work together to plan services).

Contracts/Protocols

Establish joint protocols for circumstances involving several organizations;
Describe the roles and responsibilities of each participant;
Outline funding sources for each component of the plan;
List methods to measure and evaluate the outputs, outcomes and cost-effectiveness of the programs; and,
Provide reporting mechanisms to facilitate program feedback and improvement efforts.

Coordinate Services

Coordinate screening and assessment services. One way this could be done is by offering services from a common location. Co-location allows workers to collaborate and reduces duplication of processes. Involve as many groups as possible in the community in local planning and problem solving.

Staffing Issues

Identify and develop the skills needed (such as technological training, multicultural competencies) and recruit culturally diverse workers who will relate best to the needs of special populations.

Team Meetings

Participate in team meetings, and where appropriate, take on the facilitator or other support roles. Include these activities as part of the organization's work plan as well as planning the location and time of meetings to accommodate all participants. Simple issues of accessibility are not always taken into account when planning meetings.

Decision-Making Process

There are different levels at which issues or problems may be solved or addressed. Issues arising out of situations that indicate service gaps, inefficiencies, need for protocol changes or positions requiring advocacy at the local, regional or provincial levels, may be brought forward for consideration and review by decision makers.

Form 9 – Documenting and Reporting Success and Challenges – This form may be used to forward issues to an appropriate decision maker. If the issue is not resolved at the first level, it needs to be forwarded to the next level, and so on. In turn, decisions or actions related to the issue can be documented on the form and a copy provided to the originator.

Appendix A

Forms for Recording Integrated Supports and Services Planning Activity

Form 1 - Integrated Supports and Services Planning Screening Checklist

	Check if Yes
Does the individual believe that a holistic integrated approach would be of benefit?	
Does the individual have multiple and/or complex needs?	
Does the family have more than one member with human service needs?	
Does the individual(s) require services from more than one agency, sector or worker?	
Are two or more human service workers, agencies and/or sectors currently involved or needed?	
Other approaches to planning for needs have not worked and the individual has some of the above characteristics.	
The individual(s) is unable to independently plan for their own needs and the individual has some of the above characteristics.	

Comments:

A YES answer to one or more of the above statements indicates individual(s) may be appropriate for the Integrated Supports and Services Planning Process. Plan an initial team meeting.

Form 2 - General Information

Name of Individual: _____

Birth date (Age): _____ Phone: _____

Address: _____

_____

_____

Person Completing Form: _____

(relationship to individual): _____

Date Information Collected: _____

Significant Others. (* indicates people the individual lives with):

Name	Relationship	Contact Information

Form 3 - Supports and Services Planning Team

Name of Individual: _____

Team Lead/Facilitator: _____

Date Team Established: _____

Name	Phone/Fax	Agency/Address

Form 4 - Assessment Summary

Name of Individual:

Team Lead/Facilitator:

Date of next meeting:

Date of Assessment:

First document the individual's perspective for each area:

Focus	Strengths (Dreams, goals and ambitions)	Current situation and needs
Connections and Support Network *Primary Presenter:*		
Guardianship, Trusteeship and other legal issues *Primary Presenter:*		
Cultural Considerations *Primary Presenter:*		

Form 4 - continued
Integrated Supports and Services Planning Assessment Summary

Focus	Strengths (Dreams, goals and ambitions)	Current Situation and Needs
Health Status and Care *Primary Presenter:*		
Living Arrangement *Primary Presenter:*		
Personal Management *Primary Presenter:*		

Form 4 - continued
Integrated Supports and Services Planning Assessment Summary

Focus	Strengths (Dreams, goals and ambitions)	Current Situation and Needs
Income and Financial Issues *Primary Presenter:*		
Education and Training *Primary Presenter:*		
Employment or Career Development *Primary Presenter:*		
Social, Recreational and Spiritual Development *Primary Presenter:*		
Other *Primary Presenter:*		

Form 5
Integrated Supports and Services Plan

Name of Individual: _____

Team Lead/Facilitator: _____

Date Developed: _____

Date of Next Meeting: _____

Focus	Goals	Actions	Responsibility	Individual Approval
Connections and Support Network				
Guardianship, Trusteeship and other legal issues				

Form 5 - continued
Integrated Supports and Services Plan

Focus	Goals	Actions	Responsibility	Individual Approval
Health status and care				
Living arrangement				
Personal management				

Form 5 - continued
Integrated Supports and Services Plan

Focus	Goals	Actions	Responsibility	Individual Approval
Income and financial issues				
Education and training				
Employment and career development				

Form 5 - continued
Integrated Supports and Services Plan

Focus	Goals	Actions	Responsibility	Individual Approval
Social, recreational and spiritual development				
Other (Please list)				

Form 6
Integrated Supports and Services Monitoring

Name of Individual: _____

Team Lead/Facilitator: _____

Date Developed: _____

Date of Next Meeting: _____

Focus	Status of Goals	Plan Modification	Individual Approval
Connections and Support Network			
Guardianship, Trusteeship and other legal issues			

Form 6 - continued
Integrated Supports and Services Monitoring

Focus	Status of Goals	Plan Modification	Individual Approval
Health status and care			
Living arrangements			
Personal management			

Form 6 - continued
Integrated Supports and Services Monitoring

Focus	Status of Goals	Plan Modification	Individual Approval
Income and financial issues			
Education and training			
Employment or career development			

Form 6 - continued
Integrated Supports and Services Monitoring

Focus	Status of Goals	Plan Modification	Individual Approval
Social, recreational and spiritual development			
Other (Please list)			

* Space for individual initials or check mark to indicate individual's agreement with plan, where applicable.

Form 7
Integrated Supports and Services Evaluation

Name of Individual: _____

Birth Date/Age: _____

Date of Closure: _____

Team Lead/Facilitator: _____

Date Team Established: _____

Focus	Plan Implemented	Plan Effective	Individual Comments
Connections and support network			
Guardianship, trusteeship and other legal			
Cultural considerations			
Health status and care			
Living arrangement			
Personal management			
Income and financial			
Education and training			
Employment or career development			
Social, recreational and spiritual development			
Transportation			
Other			

Form 8
Integrated Supports and Services Transfer or Closure

Name of Individual: _____

Birth Date/Age: _____

Team Lead/Facilitator: _____

Date: _____

Reason for Transfer or Closure:

Individual's Comments:

If transferred, referred to: _____

Form 9
Integrated Supports and Services Planning Documenting and Reporting

Successes and Challenges

From: _____ (name, title, agency)

To: _____ (name, title, agency)

Success:

Description of Situation: _____

What worked? How? Why? (Things to be noted for future): _____

Form 9
Integrated Supports and Services Planning Documenting and Reporting

Successes and Challenges

Challenge:

Description of situation/issue:

What worked? Why?

Suggested action or decision:

Action or decision:

Signature of Originator Date Signature of Decision Maker Date

Tool 1

Check Your Belief System

Instructions: You have a total of 25 belief points to assign to the following statements according to how strongly you agree with them. Assign all 25 points to one statement or divide them up as you wish leaving blank those that do not fit in with your beliefs and practice.

Points

_____ It is my philosophy to look at individual and family strengths and to help individuals and families use them as part of what we do, rather than correcting "deficits".

_____ I never push my beliefs on the individual and family. I respect their decisions and maintain confidentiality about what the individual and family shares with me.

_____ I believe that individuals should have the final say in what services they receive.

_____ A family is a culture unto itself, with different values and unique ways of realizing dreams and solving problems.

_____ In working with families, it is my job to understand the uniqueness of each family and work at building partnerships.

_____ It is important to respect the family's choice and style of addressing issues.

_____ I realize that the family or caregiver is the constant of the individual's life and therefore has the most comprehensive picture of the individual's needs within the context of the family.

I believe that there are many ways of doing things and providing support. My job is not to convince people to do it my way, but try to translate strategies in ways that are easily adapted by the individuals and families.

I realize that it is important to acknowledge the diversity of individual needs. Only focusing on one component of need in Integrated Supports and Services Planning could create conflicts and be stressful to individuals and families.

I believe all individuals and families have strengths and inherent abilities to become partners in the Integrated Supports and Services Planning team approach.

I believe that it is important to share information with the individual and families in a respectful and sensitive manner.

I believe that informational support networks are crucial to enhance a family's ability to provide support to the individual. I believe it is important for professionals to facilitate or provide opportunities for families to make connections with each other.

It is our job to support individuals in participating in all aspects of community life. Our intervention should be provided in accordance with the principle of mainstreaming and empowering individuals to live as independently as possible.

In order to promote equitable partnerships between professionals, individuals and families, it is important that individuals and families are involved in all levels of decision making.

Cultural Competencies

Rate your skills in working with individuals/families from diverse backgrounds and ethnic groups. (circle appropriate box)

1. How readily can you identify some of your cultural biases?

1 I have no idea how cultural bias could influence the work I do.

2 I have not thought much about it at all.

3 I have some understanding of the impact of cultural influence and family influence, but have not spent much time in examining my own biases.

4 I have some idea of how my values and beliefs relate to the work I do.

5 I have spent a lot of time thinking how my cultural and family background affects my beliefs and practice; therefore, I am very much aware of my biases.

2. Do you have a good understanding of beliefs among various ethnic groups?

1 I am not sure.

2 I received some information during my professional training but need further information in this area.

3 I have attended workshops on how to work more effectively with families from other cultural and ethnic backgrounds.

4 I have spent time reviewing literature and seeking information from resource people regarding various ethnic and cultural groups.

5 I have a lot of experience working with families from various ethnic and cultural groups.

3. Do you use the following approaches to avoid the stereotyping of people from other ethnic groups?

	always (5)	often (4)	not sure (3)	seldom (2)	never (1)
Seek information from resource persons.					
Seek information from family about their priorities and practices.					
Take time to know the uniqueness of the family.					

4. Are you able to remain non-judgemental when the family's or human service providers' beliefs are drastically different from yours or may be in conflict with yours?

1 I have not thought much about this area.

2 I find it a major source of frustration.

3 I find it difficult at times.

4 I make all attempts to be non-judgemental.

5 I am respectful of family values and practice.

5. When using an interpreter, do you do the following?

	always (5)	often (4)	not sure (3)	seldom (2)	never (1)
Spend time to ensure that the interpreter has clear understanding of information you would like him/her to present.					
Ensure that the interpreter is translating information in a manner that is supportive, empowering and respectful to the family.					
Spend time to check the comfort level of the interpreter in presenting and seeking sensitive information.					
Check with interpreter whether the information presented and the terms used can be easily translated into the family's language.					
Spend time assessing the appropriateness of using family members as interpreters. Areas to be considered: • conflict of interests; and • communication barriers due to prescribed role and status within the family structure.					

If you consistently scored 4 or 5 points in every area, you are sensitive to the cultural issues in working with families. For areas in which you scored below 3 points, you will want to gain more information about cultural issues in working with families.

Listening is:

- taking in information;
- acknowledging the speaker; and
- encouraging idea-sharing.

Rate your listening skills using the following scale:

5 = always 4 = often 3 = not sure 2 = seldom 1 = never

TABLE A	always (5)	often (4)	not sure (3)	seldom (2)	never (1)
1. Do you maintain appropriate* eye contact with the speaker?					
2. Do you acknowledge the speaker by nodding your head, leaning forward and making appropriate facial expressions?					
3. Do you try to paraphrase and clarify what the speaker has said to ensure that the message you received Is accurate?					
4. Do you pay attention to the speaker's body language seek clarification with the speaker if the body language does not fit with the spoken massage?					
5. Do you work to become more aware of subject areas which may arouse a strong emotional response? (e.g. where you feel uncomfortable or angry, etc.)					

* Appropriate eye contact varies from culture to culture. In some cultures, direct eye contact is considered rude.

Rate your listening skills using the following scale:

5 = always 4 = often 3 = not sure 2 = seldom 1 = never

TABLE B	always (5)	often (4)	not sure (3)	seldom (2)	never (1)
6. Do you interrupt, ask questions or give advice while the speaker is talking?					
7. Do you allow yourself to become critical of what is being said to you?					
8. Do you get distracted or engage in private thoughts that may have some association with the context of the conversation?					
9. While listening, do you mentally rehearse your next statement?					
10. While listening, do you attempt to complete the sentence for the speaker?					

Tool 4

Information Sharing

Rate your information sharing skills using the following scale:

5 = always 4 = often 3 = not sure 2 = seldom 1 = never

1. It is my practice to share information with individuals.
( ) always
( ) often
( ) sometimes
( ) seldom
( ) never

2. I avoid using jargon when sharing information with individuals. I also take time to explain terms.
( ) always
( ) often
( ) sometimes
( ) seldom
( ) never

3. I provide opportunities for individuals and families to ask questions and review information I have shared with them.
( ) always
( ) often
( ) sometimes
( ) seldom
( ) never

4. I provide information to individuals and families in a variety of ways, including verbal communication, written information and video.
( ) always
( ) often
( ) sometimes
( ) seldom
( ) never

5. I provide opportunities for all involved family members to share information.
( ) always
( ) often
( ) sometimes
( ) seldom
( ) never

6. I realize that families may need to revisit and have further discussions about information we have shared. I ensure that there are opportunities for follow-up discussion.
( ) always
( ) often
( ) sometimes
( ) seldom
( ) never

7. I understand and pay attention to the importance of sharing information in manageable pieces with individuals.
( ) always
( ) often
( ) sometimes
( ) seldom
( ) never

8. If I do not have the answers to the questions, I do not hesitate to let the family know. If possible I will try to connect families to appropriate resources.
( ) always
( ) often
( ) sometimes
( ) seldom
( ) never

9. I work hard at presenting a realistic picture of the individual's abilities and situation without shattering hope.

( ) always
( ) often
( ) sometimes
( ) seldom
( ) never

10. At times, it may be hard to share sensitive information. I do not avoid the issue but rather make a point of being sensitive in the way I share it.

( ) always
( ) often
( ) sometimes
( ) seldom
( ) never

Now, using the following scale, add up your score and multiply by two.

5 = always
4 = often
3 = not sure
2 = seldom
1 = never

90 - 100	=	Excellent!
80 - 89	=	You have a good understanding of listening skills.
70 - 79	=	You are on the right track, but some areas need work.
10 - 69	=	Perhaps you need to take a look at your listening skills.

Team Meeting Practice

Rate your team meeting practice by using the following scale:

5 = always
4 = often
3 = not sure
2 = seldom
1 = never

1. Do you ensure that all team members (including individuals and their families) have a clear understanding of the objectives and process of team meetings?
( ) always
( ) often
( ) sometimes
( ) seldom
( ) never

2. Do you provide a wide range of options regarding team meeting times to accommodate the needs of all members?
( ) always
( ) often
( ) sometimes
( ) seldom
( ) never

3. Do you provide options regarding the location of the team meeting?
( ) always
( ) often
( ) sometimes
( ) seldom
( ) never

4. Do you provide sufficient information (e.g. assessment reports) to all members of the Integrated Supports and Services Planning team (including the individual and his/her family) before the meeting time to facilitate all members' ability to participate as equal partners in the team meeting process?

( ) always
( ) often
( ) sometimes
( ) seldom
( ) never

5. Do you provide sufficient time and opportunities for all members (including individuals and their families) to have input in setting the agenda for the team meeting?

( ) always
( ) often
( ) sometimes
( ) seldom
( ) never

6. Do you ensure that the individual, family and other team members are aware of all the agenda items for the team meeting?

( ) always
( ) often
( ) sometimes
( ) seldom
( ) never

7. Do you provide options to encourage and support individuals and families to take charge of the meeting (i.e. chairing the meeting, co-chairing the meeting or designating a team member to chair the meeting)?

( ) always
( ) often
( ) sometimes
( ) seldom
( ) never

8. Do you provide options for individuals to invite extended family members and important people in their life to team meetings?
( ) always
( ) often
( ) sometimes
( ) seldom
( ) never

9. Do you include older children and adults who are receiving treatment in your team meeting so that they can participate actively in their treatment process?
( ) always
( ) often
( ) sometimes
( ) seldom
( ) never

10. Do individuals and families have the same opportunities to edit team meeting minutes as do other team members?
( ) always
( ) often
( ) sometimes
( ) seldom
( ) never

Now, using the- following scale, add up your score and multiply by two.

5 = always 4 = often 3 = not sure 2 = seldom 1 = never

90 - 100	=	Excellent!
80 - 89	=	You have a good understanding of listening skills.
70 - 79	=	You are on the right track, but some areas need work.
10 - 69	=	Perhaps you need to take a look at your listening skills.

Group Problem Solving

The following process for problem-solving lends itself well to the collaborative nature of the Integrated Supports and Services Planning team:

To effectively solve problems that might arise, the members of the planning team must work under two common beliefs or assumptions. Members must:

- feel that they have a valid contribution to make; and
- believe that solving the problem is actually possible.

Without commitment to these beliefs, the process of problem-solving will lose its effectiveness.

All team members must also recognize that many solutions exist for every problem. The task of establishing supports and services that are flexible, comprehensive and coordinated is complex. Members must be open to give and take. There are any numbers of possible solutions, each with its own implications. Insistence on one particular ideal method, direction or end result may tie the hands of the team members and make problem-solving a frustrating experience. Flexibility and creative problem-solving approaches are crucial.

Problem-Solving

There are several steps in the problem-solving process that allow a planning team to proceed successfully to an empowering solution

1. Identify the issue.

This may seem simplistic, and it is possible team members may feel as if they already know what the issue is; however, this can be the most difficult step of all. What we originally identify as the issue may only be a symptom of the problem. It can take some probing and discussion to uncover the real issue. Questions that may help team members in defining the issue may include:

- What are we concerned about?
- What am I concerned about?
- What is not the issue?
- How is this like or unlike other situations?
- What would we like to produce or generate?

2. Generate alternate solutions

This step is an exciting one and frequently "energizes" group members. Using brainstorming techniques to develop the maximum number of possible solutions, the team members will discover a range of alternatives. At times, some of these alternatives may open up other ideas that you can save for a later time. Questions that may help to begin discussions include:

- What concerns are most urgent? Most important?
- What will happen if we do not deal with these issues?
- What are our priorities?
- What do we most hope to preserve, achieve, attain or avoid?
- What do we want most to enhance, expand or improve?
- What are our bottom-line goals and concerns?
- Where can we get help?
- What information do we have?
- What data do we need to gather before we proceed?
- Who is involved? To whom else should we speak?
- What feelings, hunches, impressions, ideas, questions or observations might be involved?
- What sources of information are available?
- What might we have overlooked?
- What has already been tried? With what results?
- Has anyone else addressed this issue?
- What clusters represent important themes or priorities?
- What strands or issues run through all these data?
- What patterns do we see in these data?
- Which concerns can be grouped together?
- What concerns or opportunities must be addressed first?

3. Evaluate the potential solutions

This step has two parts:

First, consider the positive and negative implications and consequences of each alternative. This analysis may shorten the list of alternatives.

- What might be sources of assistance and/or resistance?
- What are some possible obstacles, objections or concerns?
- How might implementation problems be avoided?
- What might we do if problems arise anyway?
- What is most likely to help us implement our plan?

Second, elaborate carefully the responsibilities associated with each alternative remaining on the list:

- What specific actions are necessary?
- What sequence of steps should be planned?
- Who will help?
- What sources and resources are needed?
- How do we start?
- What timing and location factors must be considered?
- What are the most important steps to prevent problems?
- How will we monitor and document progress?

You may wish to modify alternatives or suggest other alternatives as the discussion proceeds. The team may find it helpful to categorize the alternatives according to priority. Finally, the result of this step is a decision based on the alternative the team has chosen to pursue.

4. Implement the solution
Create a plan to implement the chosen alternative. List all actions necessary for carrying out the planned solution with timelines and document the names of people responsible for completing the tasks.

5. Evaluate the outcomes
You will have planned this step along with the actions in Step Three: evaluate the potential solutions. When the team chose the alternative for resolving the problem, you will have made plans for measuring the results of the solution. Once the solution has been implemented, you will want to make further decisions about continuing, modifying or discarding the implemented solution.

6. Redesign the solution
When you measure the outcomes, you will be able to determine whether the solution needs to be redesigned or discontinued and alternative chosen.

Solving problems effectively requires a systematic approach and hard work. However, when the planning team works together creatively, you can avoid problems or solve them as they arise. There will be a higher degree of success than if issues are left unattended.